



Vascular Society of New Jersey

Monthly Report- May 2011

From the President

Paul B. Haser, MD

The results are in: the Annual Spring Meeting was evaluated as an overall success! The recommendations appear quite appropriate and will be evaluated in terms of up-coming meeting, with a very high likelihood that the recommended topics to be covered. It is likely that more in-state representation is on the agenda from the speakers core, but your continued input is not only welcomed, but will be solicited over the Summer and Fall. Once again, we thank the sponsors for their Advamed compliant support.

<http://www.advamed.org/MemberPortal/About/code/>

Below follows the Legal Report, From the State House and Estate Planning. In the previous month, the legal topics ranged from a vacation of a proposed Horizon settlement and injunction against the filing of PICPA (also known as MAXIMUS) arbitrations - see below for more information on MAXIMUS - to the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) announced that it had entered into a Resolution Agreement with Massachusetts General Hospital (MGH) to settle potential HIPAA violations to the tune of \$1,000,000. This month finds more information regarding outpatient single unit surgical practices, reports from the OIG, and even some information regarding medical marijuana. (I think Mr. Eichler just added that at the end to peak your interest.) The Lobbying information (and work) performed by Beverly Lynch et al remains an often behind-the-scenes but extremely important element for the membership - please take moment to review what is happening to us outside of the OR and the office.

Along those lines, I attended a recently RUC meeting, (Relative Value Unit Committee - a sub-committee of the AMA, with mandates from CMS), in Chicago where saw first-hand reinforcement of what one of our past Presidents, Cliff Sales, MD, has urged all the members to complete - the RUC surveys. I will provide more information regarding this process when the next set comes out, but it would be remarkable to have a strong response from the VSNJ members to validate the hard work we do. Take a note of the Estate Planning advice, to hold on to the RVU dollars we do earn.

Lastly, the web-site will be undergoing a face-lift. Any ideas you would like to have included, please visit the page, www.vascularsocietynj.org where you will be able to find my e-mail. Send me your interest or give me a call. A Happy Spring to you all.

LEGAL REPORT

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Bill Introduced That Would Require Surgical Practices to be Licensed

On March 10, 2011, State Senators Joseph Vitale and Robert Singer introduced Senate Bill S2780 into the New Jersey State Senate, which would require one room surgical practices to be licensed by the New Jersey Department of Health and Senior Services ("DHSS") as ambulatory care facilities in order to provide surgical and related services. The bill has

been referred to the Senate Health, Human Services and Senior Citizens Committee. An identical form of the bill was introduced into the New Jersey State Assembly by Assemblyman Daniel R. Benson on March 14, 2011 and was referred to the Assembly Health and Senior Services Committee.

At present, surgical practices are required to be registered with DHSS. If passed into law, the ambulatory care facility assessment would then also apply to surgical practices. In addition, a registered surgical practice would be required to become licensed before it could be transferred to a new owner or relocate.

NJDHSS Proposes Rules Governing Surgical Practices

On April 18, 2011, the New Jersey Department of Health and Senior Services ("DHSS") issued proposed rules relating to amendments passed in 2009 to the New Jersey Code Law that require all physician surgical practices in the state of New Jersey to be registered and inspected.

The proposed rules apply to small surgical practices with no more than one operating room, which are currently regulated as private medical practices by the Board of Medical Examiners and not licensed by DHSS. Under the proposed rules, these surgical practices will be required to be inspected and either certified by the federal Centers for Medicare and Medicaid Services ("CMS") or accredited by one of four CMS-approved independent accreditation organizations. They would also be required to register annually with DHSS. The proposed rules also set forth the form and requirements for registration of surgical practices with DHSS.

Comments to the proposed rules are being accepted until June 17, 2011. Comments should reference Proposal Number PRN 2011-105 and be submitted to: Devon L. Graf, Director, Office of Legal and Regulatory Compliance, Office of the Commissioner, New Jersey Department of Health and Senior Services, P.O. Box 360, Trenton, New Jersey 08625-0360.

President Obama Signs 1099 Repeal Bill into Law

On April 14, 2011, President Barack Obama signed into law a bill to repeal the requirement under the Patient Protection and Affordable Care Act ("PPACA") that businesses file 1099s for every vendor it uses, for both services and goods, that exceed \$600 in a year.

Presently, a business must provide a 1099 to the Internal Revenue Service for any services it receives from an unincorporated entity such as a partnership. PPACA broadened this requirement to require businesses to file 1099s for every vendor it uses, regardless of its corporate status. The measure was scheduled to take effect on January 1, 2012. The provision had been criticized as placing an undue burden on small businesses. To replace the tax revenue of \$22 billion that the provision was anticipated to generate, the newly passed law will mandate that individuals pay back federal health-care subsidies if their income increases.

OIG Opinion Regarding Hospital Network's Billing Plan and Provision of Lodging and Transportation Assistance

Earlier this year, the United States Department of Health & Human Services Office of Inspector General ("OIG") issued an advisory opinion approving the plan of a network of pediatric charity hospitals to: (1) begin billing third-party payers, including federal health care programs, for services rendered and waiving all patient cost sharing amounts; (2) provide lodging assistance to certain patients; and (3) provide transportation assistance to certain patients.

Although the OIG has issued guidance that waivers of patient co-payments should occur only on a case-by-case basis based on financial need, the OIG determined that it would not impose sanctions for violation of the federal anti-kickback law related to the proposed plan for several reasons, including: (1) the pediatric hospitals in the network have provided free care to patients for many decades (predating Medicare and Medicaid) and have provided care uniformly to all patients; (2) if the insurance-only billing plan is not implemented, the network may be forced to close certain hospitals; (3) very few patients are covered by federal health insurance plans; (4) the medical services are highly specialized in nature; (5) compensation for hospital-employed physicians is fixed; and (6) cost-sharing waivers are available to all patients, and, moreover, only after they choose the hospital for treatment.

The OIG also determined that it would not impose sanctions for the provision of certain lodging and transportation assistance based upon financial need because: (1) a recent amendment to the anti-kickback law excludes from the definition of remuneration, remuneration which promotes access to care and poses a low risk of harm to patients and federal health care programs; (2) the assistance would be provided only in the context of a financial need determination and when the hospitals deem assistance is merited based upon the patient's medical situation; (3) the assistance would not be advertised; and (4) patients would be informed of the assistance after acceptance of treatment.

OIG Advisory Opinion 11-02 Allows Complementary Transportation Services

On March 17, 2011, the United States Department of Health & Human Services Office of Inspector General ("OIG") issued another favorable opinion regarding complementary transportation services. Advisory Opinion 11-02 scrutinized a proposed arrangement to provide complementary transportation of patients to the hospital from physician offices located on, or adjacent to, the hospital campus. The transportation services would be provided by the hospital if physicians on the medical staff determine that a patient is in immediate need of treatment and there are no available private transportation options. The value of this transportation could be more than a nominal value, exceeding ten dollars per transport or fifty dollars annually.

The OIG stated that the proposed arrangement potentially implicates the federal anti-kickback statute and the civil monetary penalties law because such transportation might be offered to induce beneficiaries to obtain federally payable items or services from the hospital. However, the OIG determined that it would not impose sanctions based on a combination of factors:

- The proposed arrangement would not be limited to transportation of federal healthcare program beneficiaries and eligibility for the transportation services would be determined by physicians according to the hospital's written policy;
- The type of transportation, a van owned by the hospital and driven by an EMT employed by the hospital, would be reasonable;
- The hospital would only offer transportation services from physicians' offices located on or contiguous to the hospital's 108-acre campus, approximately 1/4 of a mile;
- The proposed arrangement would not be advertised by the hospital;
- There is limited access to and availability of local public transportation; and
- The hospital would not claim (directly or indirectly) the cost of transportation on any federal healthcare program cost report or claim, nor otherwise shift the cost to a federal healthcare program.

Medicinal Marijuana Operators Identified

Despite regulations not yet being finalized, the New Jersey Department of Health and Senior Services ("DHSS") has identified the six nonprofit entities that have been selected to operate alternative treatment centers ("ATCs") for New Jersey's Medicinal Marijuana Program: Foundation Harmony, located in Secaucus, Hudson County (Northern Region); Greenleaf Compassion Center, located in Montclair, Essex County (Northern Region); Breakwater Alternative Treatment Center, located in Manalapan, Monmouth County (Central Region); Compassionate Care Centers of America Foundation, located in New Brunswick, Middlesex County (Central Region); Compassionate Care Foundation, located in Bellmawr, Camden County (Southern Region); and Compassionate Sciences, located in either Burlington or Camden counties (Southern Region).

The public comment period on the proposed rules ended on April 23, 2011. Once the regulations are adopted, the approved ATCs can begin to cultivate and sell marijuana to patients registered with DHSS.

Member Questions and Answers

Asked recently by a VSNJ member....

Assignment of Benefits Law- the promised "solution" to having checks payable to the patients has failed to fix the problem. Our office has learned that many of the Blue Cross patients are in "self-funded" plans, which are apparently exempt from the assignment of benefits law. So there are still a lot of patients who are receiving checks for services provided by the doctor. Those checks are often cashed by the patient and our office often has no recourse other than to sue the patient for the money. This situation is made worse by the fact that our office is not sent a copy of the explanation of benefits statement, so we don't even know that the patient has been paid. Suggestions/solutions?

Response:

The State of New Jersey does not regulate self-funded plans, which are governed by ERISA law (federal law). Thus the AOB law doesn't reach self-funded plans.

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Maximus Arbitration Process- As you know, it is common for an insurance company to deny a physician's claim or underpay the billed amount. There is little direct recourse for the physician's office except to appeal back to the company, which is often denied. I was, therefore, pleased when the State announced that it subcontracted with Maximus to arbitrate these disputes. I have sent several cases to Maximus. All have been rejected by Maximus, claiming it is not within their ability to review. The first case was rejected because it was more than 90 days since the claim was denied. This was, of course, because we were waiting for the outcome of the reprocessing and re-appeal of our claim. These problematic cases are often delayed because of back and forth correspondence and it makes no sense to have a 90 day window.

Having learned from that initial appeal that the cases need to be sent within 90 days, we have sent a few additional cases for review and arbitration. Maximus requires a \$50 fee to simply open a case file. They promptly rejected the other cases, stating that they have no authority over the specific insurance plans, who had not agreed to the arbitration process. They did not refund the money for the review. It makes no sense to me. They should be able to tell us whether they can review a claim based on the insurance without charging a fee and opening a case file; this information is not available on their website or in any other listing that we have found. Also, as each of these insurance carriers can only operate in NJ with the blessing of the State Department of Banking and Insurance, they could be made to participate with the arbitration process or provide a parallel service.

Response:

By statute, insurance carriers that are licensed in the state of NJ are subject to the MAXIMUS arbitration process. They do not need to agree to be subject to the process, they automatically are. Those carriers that do not issue policies in NJ are not subject to these laws because they don't transact business in the state. Similarly, self-funded plans (which are governed by the federal ERISA law) and State Health Benefits Program plans are not subject to this requirement.

A problem that providers often run into is determining in advance whether a claim is eligible for

arbitration and if they will arbitrate it. The initial \$50 MAXIMUS fee is indeed non-refundable (there is also a non-refundable \$130 arbitration fee, once the claim is accepted). Unfortunately, it is not always clear to the provider whether a claim is eligible for arbitration or even worth arbitrating. There are a number of things that I look for when evaluating claims for eligibility (insurance carrier, policy number, employer information, etc). But often, it goes beyond that and involves a cost-benefit analysis as well. For example, because my experience has shown me that certain procedure codes are not typically granted favorable awards by MAXIMUS, I am able to identify them in advance and not submit certain claims in the first place.

The back and forth between the provider and the carrier can become problematic when it comes to timing. This can be fixed, however, if there is a streamlined process in place for handling appeals. You need to utilize all the proper appeal and consent forms, and maintain good mail tracking records. Furthermore, you do not always need to wait for the carrier to respond to an appeal in order to arbitrate a claim (though the appeal to the carrier must be made in timely manner and with the DOBI prescribed form). Another option that many providers aren't aware exists is the ability to appeal allegations of overpayments by a carrier, but this requires meeting different shorter filing deadlines. Waiting too long can prejudice your ability to arbitrate such claims as well.

Please feel free to contact me if you would like to discuss this in greater depth.

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Discipline rate of problem physicians subject of hearing

A report that claims New Jersey is not disciplining enough problem physicians led to a Senate committee hearing last month. A report produced by the nonpartisan Public Citizen claimed that, among other things, New Jersey is one of 32 states in which more than 50 percent of physicians with complaints logged in a national data bank received no further licensure action at the state level. The report states that from Sept. 1, 1990, to the end of 2009, N.J. hospitals took disciplinary actions against 320 physicians logged in the National Practitioner Data Bank, yet 57 percent of them - 183 - never had any further state medical board disciplinary action. The data bank tracks malpractice payouts or disciplinary action against physicians.

"The state medical board has failed to take any action against a large number of its licensed physicians who have been found by New Jersey hospitals to have been unable to practice safely, to have exhibited incompetence, negligence, or substandard/inadequate care or skill levels, or to have engaged in professional misconduct," Dr. Sidney Wolfe of Public Citizen testified. The report gave case histories regarding N.J. physicians, without identifying them by name. For example, the report cited a case in which the state board took no further action after a hospital permanently revoked admitting privileges of a physician who had eight malpractice payouts totaling approximately \$2.7 million. Wolfe said that New Jersey's ranking among the 50 states in terms of disciplinary actions dropped from a high of 18th and 19th in 1993 and 1994 to a low of 41st and 40th in 2008 and 2009.

During his testimony before and subsequent questioning by members of the Senate Health, Human Services

and Senior Citizens Committee, he attributed some of the problem to insufficient staffing and funding for the state Board of Medical Examiners, as well as the fact the board does not have a full-time medical director, although it is seeking to staff that position on a part-time basis. In addition, Wolfe pointed out to the committee that since 1989, the state has had a Medical Practitioner Review Panel that receives reports about problem physicians, does a preliminary investigation, and makes recommendations to the Board of Medical Examiners. He urged the committee to find out how many of the 183 physicians whose cases the Board did not act on were recommended for Board action by the review panel. He also urged the board to have staff visit other states that he believes are doing the job well. Wolfe said that at one time, Arizona ranked 38th in the nation, but after devoting more resources to the problem, tripled their rate of disciplinary actions within three years, and that Colorado does not have as many staff as some states but has consistently ranked high in disciplinary action.

Lawmakers expressed concern regarding the report's findings. During the hearing, committee chairwoman Sen. Loretta Weinberg, (D-37), Bergen, said it was important to make sure that they were comparing apples to apples when comparing enforcement actions among states. "I am concerned about the staffing levels," she said of the N.J. Board. "We need to make sure that the Board has the tools it needs to pursue cases of suspected wrongdoing, and to make sure doctors and other health care professionals are held to the highest professional standards," she said after the hearing.

But Lawrence DeMarzo, of the N.J. Division of Consumer Affairs, told the committee that while they respect Wolfe as a watchdog, they disagree with his findings. "In our view, the notion that the Board should publicly discipline every physician reflects a basic misunderstanding of the various functions of the Board," he said. "Remediation," he said, "often returns a competent physician to practice who is no threat to public safety."

The report said that some 'serious' offenders went undisciplined. "Public Citizen used the term 'serious.' Our point is that regardless of the definition, in raw numbers, each and every report was carefully reviewed and appropriately handled in the judging by the panel," DeMarzo testified. "The public should have confidence that their interests are well protected."

No action was taken by the Senate committee; the hearing was held to gather information on the situation.

Asset Protection Strategies

One of the greatest threats to your personal assets is the potential expense of a long term illness. According to a recent study done by Genworth Financial (3/2010) the average expense of providing long term care in central New Jersey is \$100,923 per year. To make matters worse these expenses are increasing, on average, by about 5% every year. The average length of care is about 4 years; 1 ½ years at home and 2 ½ years in a facility. Based on these assumptions, in the event of an illness, your assets could have an exposure of \$434,990 today. If these assumptions hold true your exposure would grow to \$708,553 in 10 years and \$1,154,158 in 20 years. This is per person. So a married couple could have twice that exposure.

The best strategy to protect your assets from this threat is Long Term Care insurance (LTC). Many of you have taken my advice and purchased this insurance. And many of you are having your practice pay the premiums which is the most efficient way to do it. However, many of you are not taking the income tax deductions that you are entitled to. If your practice is set up as an S-Corp, LLC, or PA, the practice pays the premium, takes a deduction, and passes on the cost of the premium to you as ordinary income. Your accountant is then supposed to deduct the premium from your personal tax return. Unfortunately, most accountants are treating your premiums as ordinary medical expenses which are not deductible until all of your medical expenses in aggregate exceed 7.5% of your adjusted gross income (AGI). For example, if your AGI was \$500,000 last year you could not start deducting your medical expenses until in aggregate they exceeded \$37,500. This would be true if you paid for long term care insurance yourself. However, by having your practice pay your premiums

you are exempt of the 7.5% threshold and premiums are deductible based on the following age based scale for 2011:

Ages 51-60 \$1,270

Ages 61-70 \$3,390

Ages 70+ \$4,240

So a married couple who are both 61 this year could each deduct up to \$3,390 of their premiums.

For those of you who haven't purchased LTC yet I would strongly urge you to do so. Many providers are finding that they have underpriced their policies and as a result will be issuing new policies with higher premiums (and in many some cases decreased benefits). Now is a perfect time to take advantage of your VSNJ membership discounts. As a member, you are entitled to exclusive discounts from many premier providers including Guardian, Prudential, and John Hancock.

Please contact us for addition information at (877)972-7900 or dvargo@varbeco.com.

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